Idaho State Board of Pharmacy

3380 Americana Terrace #320 PO Box 83720 Boise, ID 83720-0067
Telephone 208/334-2356 Fax 208/334-3536

REQUIRED DOCUMENTS – DURABLE MEDICAL EQUIPMENT OUTLET

Photocopies of the following documents are required* for Durable Medical Equipment Outlet registration applicants and must be submitted with the application form and fee:

- A copy of the current resident state license (if outside of Idaho)
- A copy of the current facility inspection report issued by the resident state. (If outside of Idaho)
- Complete list of products carried
- A list of corporate officers/partners

*Applications for facilities in Idaho need only submit the list of corporate officers/partners with the application and fee

Note: The name (or names) and address on the state license/registration copies submitted to support an application must match the name (or names) and address listed on the application. Applications submitted without matching name/address documents will be returned unprocessed.

Medical Equipment (DME) Outlet (7-1-98)

a. All entities holding for sale legend or non-legend devices to be sold at retail or wholesale must be registered with the Board. Said legend devices may only be sold or delivered at retail upon the lawful order of a practitioner. DME outlets may hold non-legend drugs for sale.(7-1-98)

b. Registered DME outlets may hold for sale at retail only upon the order of a practitioner, the following legend drugs:(7-1-98)
   i. Pure Oxygen for human application.(7-1-98)
   ii. Nitrous Oxide.(7-1-98)
   iii. Sterile Sodium Chloride.(7-1-98)
   iv. Sterile water for injection.(7-1-98)

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Application for Idaho Registration
Durable Medical Equipment Outlet

INCOMPLETE FORMS WILL NOT BE PROCESSED

Annual Fee: $50

Type of Application: ***(circle)*** **New Ownership Change Name Change Address Change**

Previous Idaho Registration #: _____ Name: _____

Name of Business: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: _____ Fax: _____

Contact Person/Owner: _____ Phone: _____

Resident State: _____ License #: _____ Expiration: _____

License Type: _____ Issuing Agency: _____

Type of Ownership: ***(Circle and attach listing of officers, partners, etc., with addresses and phone for each)***

Partnership Sole Proprietorship Corporation Limited Liability

Agency Performing Inspections: _____

Type of Operation: ***(Circle all that apply)***

Oxygen Supplier Legend Medical Devices Home Care Supplies

Other: ***(Explain)*****: _____**

*****ATTACH INVENTORY LIST*****

Have any of the applicants had: (*If answer is yes to any of the following attach documentation)*

Felony convictions under federal, state or local laws? _____ No _____ Yes

Suspensions or revocation of licensure for the manufacturing or distributing of drugs, including controlled substances, by federal, state or local laws of any license currently or previously held by applicants? _____ No _____ Yes

Have any application for licensure been denied by any federal, state or local agency? _____No _____ Yes

_____ _____
Signature of Corporate Officer Date